Influenza Vaccination Screening and Consent Form

Please check √ Yes or No to the following questions. Please answer all questions.

General Medical Questions	Yes	No
1. Do you have a fever or feel sick today?		
2. Have you ever had a serious reaction to a flu vaccine or a component in the vaccine (MSG, arginine, gentamicin, and gelatin)?		
3. Have you ever had a severe allergic reaction to eggs that required medical attention?		
4. Have you ever had Guillain-Barré Syndrome (GBS)?		
Section A: Inactivated Influenza Vaccine (TIV)	**Yes**	**No**
1. Do you have a severe allergy to thimerosal, a preservative used in some vaccines?		
2. Do you have an allergy to latex?		
Section B: Live Attenuated Influenza Vaccine (LAIV)	**Yes**	**No**
1. Could you be pregnant?		
2. Do you have any of the following long-term medical conditions? • Asthma • Heart disease • Lung disease • Kidney disease • Metabolic disease (such as diabetes) • Liver disease (hepatitis, cirrhosis) • Blood disorder (leukemia, lymphoma, sickle cell disease)		
3. Have you been diagnosed with wheezing in the last 12 months?		
4. Do you have a weakened immune system due to HIV/AIDS or other diseases affecting the immune system, long-term steroid therapy, or cancer treatment with drugs or x-rays?		
5. Do you have a muscle or nerve disorder that can lead to breathing or swallowing problems such as a seizure disorder or cerebral palsy?		
6. Is your child currently receiving long term aspirin therapy or a medicine containing aspirin?		
7. Have you received MMR (measles-mumps-rubella), Varicella (chickenpox) vaccine or a live influenza vaccine within the last 4 weeks?		
8. Do you live with or have close contact with a person who has a severely weakened immune system who must be in a protective environment such as a hospital room with reverse air flow (for example a bone marrow transplant unit)?		
1. Did you receive at least one dose of seasonal flu vaccine last year?		
2. What is your date of birth?	__ __/__ __/ __ __ *(example 05/08/80)*	

CONSENT FOR VACCINATION

I have read the Influenza Vaccine Information Statement (VIS) dated 07/26/2011 for the Influenza Vaccine and understand the risks and benefits of the vaccine. I have had a chance to ask questions. I give permission to receive the flu vaccine.

_____

Signature of person to receive vaccine (or person authorized to make the request Date -_____

CAIR NUMBER _____
Staff name _____
Date _____

Imprint name ID Card (Name MRUN CLINIC/WARD)